AUTHORITY FOR RELEASE AND EXCHANGE OF INFORMATION
FORM R-407 REV. 02-01

INSTRUCTIONS FOR COMPLETION

(1) Type or print clientõs name.

(2) Date of birth and/or other identifier. Certain information sources may be assisted by date of birth and other identifier. Other identifiers may include Social Security number, hospital patient number, insurance or VA claim number, etc.

(3) The addresses entered here should always be the agency, clinic, facility, or group from which the information is being sought.

By addressing it to: IVRS, the client can request our agency to release selected information to some other agency/facility/individual, which would be identified in #4.

(4) The same principles apply as in instructions #3, above. Generally, the information is to be delivered to: IVRS, local office address, ATTENTION: specific counselor.

(5) If reports of a specific date or time period are wanted, enter the date(s) here. If dates are unknown, this may be left blank.

(6) Check all of the types of information that apply. Types of information not listed may be specified under ñOther.ò

(7) The usual purposes for which IVRS uses information are printed here. Only when information is needed for some other purpose is the ñOtherò checked and an entry made on the line following.

(8) This item is intended to accommodate any changes or modifications in the basic terms of the release authority that would be agreed upon and appropriate. For example, there may be reasons the counselor and client would agree to change the expiration date of the release to some other reasonable period after the date of signature; or, the client may desire to have the counselor provide periodic progress reports during his rehabilitation program to the addressee. The use of this item depends entirely upon the circumstances. In a majority of situations, it will be left blank.

(9) The expiration date may not exceed 12 months for medical and psychological information exchange in accordance with HIPAA. The release may exceed 12 months only when the information exchanged is with an appropriate service provider and is related to educational and work performance progress.

August, 2007

(10) Client signature, date, and address will generally be adequate for most routine requests.

(11) Parent or guardian signature is required if the client is under age 18. There may also be cases in which the signature of a parent/guardian/responsible agent should be obtained as a matter of principle, particularly when mental competency due to severe retardation or psychiatric illness is an issue. If a signature is obtained from other than a parent or guardian, the relationship should be noted below the signature.

(12) A counselor, secretary, supervisor, or other individual can sign as the witness.

(13) The sole purpose of requiring a separate signature in this item, as well as in #10, is to provide evidence that the client is aware that substance abuse, mental health, and HIV information is being requested and disclosed. It is essential for compliance with federal law. Even if no such information is being anticipated, many providers require this to be signed to protect them from inadvertent release of the protected information. For those individuals with a legal guardian, both signature lines should be completed.

NOTE: UNDER NO CIRCUMSTANCES IS AN INCOMPLETE FORM TO BE SIGNED AND INCLUDED IN A IVRS CASEFILE.

CASEFILE COPY: Prior to sending out a release, a copy is to be made and filed in the section of the client casefile which relates to the type/nature of the material requested; i.e., medical, psychological, social, etc. A handwritten ñdate sentò notation on the casefile copy should be made as such would prove helpful in the event that follow-up is necessary due to non-receipt. When received, the report or other material should be associated with the R-407.

When IVRS information is released to some other party, a copy is to be made and the original R-407 sent with the material. The copy should be filed in the correspondence section of the casefile.

In most instances, these copies of the R-407 will eliminate need for any additional cover letter and will serve as evidence of the requests and action taken in response.

State of Iowa
Department of Education
IOWA VOCATIONAL REHABILITATION SERVICES

RE: **1.** _____
NAME *(Typed or Printed)*
SS#
2. _____
DATE OF BIRTH *and/or* OTHER IDENTIFIER

AUTHORITY FOR RELEASE AND EXCHANGE OF INFORMATION

To: **3.**	**I, the undersigned, hereby authorize you to disclose and deliver to: 4.**

THE FOLLOWING SPECIFIC INFORMATION: APPROXIMATE DATE OF REPORT(S): **5.** _____

6.
- ☐ **Medical: Evaluation and/or Treatment Reports**
- ☐ **Hospital: Admitting History/Exam, Consultant Exam and Discharge Summary**
- ☐ **Psychiatric: Discharge Summary Letters and Clinical Notes**
- ☐ **Psychological: Evaluation and/or Treatment Reports**
- ☐ **Transcript of Grades or other Performance Report**
- ☐ **Other** _____

I understand that the information you release will be used as appropriate and necessary in the determination of eligibility for, and the development of a program of rehabilitation services; or

7. ☐ **Other** _____

I understand that the information may be given verbally or in written form and this release includes permission to furnish copies. I understand a copy of this form will accompany any written information released and I will also receive a copy at the time of disclosure. This form will also be kept in my VR casefile. I understand that I may review the disclosed information by contacting the person, agency, or individual releasing the information. I understand that the information will be used for purposes relating to my rehabilitation programming, and will not be released to any other agency, individual or organization for any other purpose as required by Federal or State Law. I understand that any action on my part to deny access to information that is essential to my rehabilitation programming may result in delaying or stopping rehabilitation services. I also understand that I may withdraw this permission at any time by sending written notice to the Iowa Vocational Rehabilitation Services, 510 East 12th Street, Des Moines, Iowa 50319. If I do so, I know that it cannot apply to any information that has been given before IVRS has received my written withdrawal and notified the supplier named above. In the absence of any withdrawal, or special instructions below, this release will automatically expire 12 months from the date of my signature.

8. **Restrictions and/or Comments:** _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:

If information of the following types is available I give permission for its release: *(Client must check appropriate box[es])*

	YES	NO
1. SUBSTANCE ABUSE	☐	☐
2. MENTAL HEALTH	☐	☐
3. HIV-RELATED INFORMATION	☐	☐

13. _____
SIGNATURE OF CLIENT ***DATE***

_____
SIGNATURE OF LEGAL GUARDIAN *DATE*

In order for the above information to be released, you must sign here AND to the right.

10. _____ **9.** _____
CLIENT SIGNATURE **DATE SIGNED**

_____
STREET/P.O. BOX

_____
CITY/STATE/ZIP

11. _____
PARENT/GUARDIAN IF CLIENT IS A MINOR

12. _____
SIGNATURE OF WITNESS

For Responding Agency Use Only:

_____**Staff Initial** _____**Date Released** _____**Date Copy Sent to Client**

R-407 Revised 02/08

Iowa Vocational Rehabilitation Services